

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00753

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md.		
Howard				b. COUNTY		Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Rural Marriottsville		Life		Rural Marriottsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR-INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Mt. Zion		Mt. Zion						
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year
IDA		MAY	AMOS	SS	JANUARY	15	1960	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
F.		W		JULY 30, 1883		77		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife		Home		Md.		U. S. A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Milford D. Shipley		Frances M. Shipley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no		none		Mrs. Howard E. Hale - Marriottsville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral thrombosis, arteriosclerosis						
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) Generalized, rheumatic heart disease (c) Hypertension, renal failure						Dec 59 to 1 Jan 60
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
19								
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above.								ADDRESS (Street, city or town, state)
ACTUAL SIGNATURE		Howard E. Hale						DATE SIGNED Jan 50
PHYSICIAN'S NAME (Type)		Howard E. Hale						SYkesville, MD.
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIY		22d. LOCATION (City, town, or county)		(State)
Burial		1-4-60		Mt. Zion		Howard Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Arthur S. Haight		Sykesville, Md.		JAN 5 '60		Arthur S. Haight		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00754

0754 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City, 12h.		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		d. STREET ADDRESS 8 - 7 th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Robert Lost Arvin		4. DATE OF DEATH Month January Day 24 Year 1960	
5. SEX M 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Febr. 7 th 1895	
9. AGE (in years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 71 Days 16 Hours 1 Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car repairman		10b. KIND OF BUSINESS OR INDUSTRY B & O Railway	
11. BIRTHPLACE (State or foreign country) Brunswick, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Arvin		14. MOTHER'S MAIDEN NAME Anna Rebecca Kidwiler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT wife Viola Arvin 8 - 7 th Ave., Brunswick		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriesclerotic Cardio-vascular disease DUE TO (c) Drug addiction, Barbiturates	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 230 p.m. 1/23, 1960, to 1/24 1 ⁴⁵ a.m. 1960, that I last saw the deceased alive on 1/24, 1960, and that death occurred at 1 ⁴⁵ a.m. from the causes and on the date stated above. ACTUAL SIGNATURE Irving J. Taylor PHYSICIAN'S NAME (Type) Irving J. Taylor		22d. LOCATION (City, town, or county) (State) Taylor Manor Hospital 1/24-1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-1960	
22c. NAME OF CEMETERY OR CREMATORIUM Edge Hill		22d. LOCATION (City, town, or county) (State) Charlestown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Feete		24a. REC'D. BY REGISTRAR JAN 27 '60	
ADDRESS Brunswick, Maryland		24b. REGISTRAR'S SIGNATURE JAN 27 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

0765 CERTIFICATE OF DEATH

00755

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		Howard	
TOWN		10 yrs		TOWN		Howard	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
Box 135 Florey Rd				Box 135 Florey Rd			
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
William L. Basil Jr				Jan 3 1960			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	White	MARRIED	90ex 1895	64	Months	Days	Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
TVA R (Ret)				Balto Md			
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William L. Basil Jr				Olela Hutchinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
(If Yes, give war or dates of service)				715-09-0716			
17. INFORMANT & ADDRESS							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A)				Acute coronary occlusion 2ds			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B)				Chronic Myocarditis 2-4 yrs			
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Hypertension 3 yrs			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Diabetes Mellitus 10 yrs			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. HOW DID INJURY OCCUR?			
M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
22. I hereby certify that I attended the deceased from , 1960, to Jan 3, 1960, that I last saw the deceased alive on Jan 2, 1960, and that death occurred at 175 M. from the causes and on the date stated above.							
SIGNATURE <i>J. P. Brumbaugh</i> M.D. ADDRESS (Street, city, town, state) <i>6009 Main St Elbridge 2734</i> DATE SIGNED <i>1/3/60</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county) (State)	
Burial		6 Jan 1960		Meadowridge Cem		Howard Co Md	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
JAN 5 '60		Arthur S. Thoms		R. H. C. & B. M. Walters		Preston Street, Elbridge, Md	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 & 13. Film G-256 2/12/60.cac.

00756

0755

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		b. COUNTY Howard	
c. LENGTH OF STAY IN lb 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		d. STREET ADDRESS Temora	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First	Middle
4. DATE OF DEATH		Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
1880		Oct 29, 1880 1890. 79 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Washington, D. C.		11. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Cavell Breckinridge		14. MOTHER'S MAIDEN NAME Louise Ludlow Dudley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
17. INFORMANT		Address	
Wife- Varina H. Breckinridge, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X		3 days	
DUE TO Cerebral Thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cerebral arteriosclerosis		2 years	
DUE TO (c) Generalized arteriosclerosis		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1960, to Jan 31, 1960, that I last saw the deceased alive on Jan 31, 1960, and that death occurred at 7:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Irving J. Taylor		DATE SIGNED 1/31/60	
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D.		M.D. Taylor Manor Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-3-60	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet		22d. LOCATION (City, town, or county) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR FEB 3 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Curtis S. House	

TO HOSPITAL
may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0755

CERTIFICATE OF DEATH

Reg. Dist. No.

00757

1. PLACE OF DEATH a. COUNTY <i>HOWARD</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i>		b. COUNTY <i>BALTO</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELLIOTT CITY</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>		0352-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SCHAFFERS NURSING HOME</i>		d. STREET ADDRESS <i>501 NEWBURG AVE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>SYLVESTER E. BROOKS</i>		First	Middle	Last	4. DATE OF DEATH <i>JAN.</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT. 8, 1871</i>		9. AGE (In years last birthday) <i>88</i> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SUPT. - RET.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CEMETERY</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>JOHN T. BROOKS</i>		14. MOTHER'S MAIDEN NAME <i>ELLA S. NIEHOFF</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT <i>Mrs. Milton Brown - 501 Newburg Ave.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i>		DUE TO <i>Sobow Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO <i>Congestive Heart Failure</i>		7 days				
(c)		DUE TO <i>Arteriosclerotic heart disease</i>		5 years more				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Accidental fall - exact nature unknown.</i>						
20c. TIME OF INJURY Month, Day, Year ? Hour o. m. 1/1 1960 p. m. 1/1 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Nursing Home</i>		20f. (City or town) <i>ELLIOTT CITY</i>	(County) <i>Howard</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Dec. 11, 1959</i> to <i>Jan. 7, 1960</i> , that I last saw the deceased alive on <i>Jan. 7, 1960</i> , and that death occurred at <i>11:00 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>M.D. 6348 FREDERICK RD</i>		DATE SIGNED <i>Jan 8, 1960</i>				
ACTUAL SIGNATURE <i>John N. Snyder</i>		PHYSICIAN'S NAME (Type) <i>JOHN N. SNYDER MD</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22c. DATE THEREOF <i>1-9-60</i>		22d. LOCATION (City, town, or county) <i>BALTO.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Foley Funeral Home</i>		ADDRESS <i>Catonsville Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 12 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00758

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		0766		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine		c. LENGTH OF STAY IN 1b 4 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Mt. Airy		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ROSIE		First I.	Middle CRABB	Last	4. DATE OF DEATH JAN. 16,	Month JAN.	Day 16,	Year 1960
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH 2-16-1883	9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Thomas Wetzel		14. MOTHER'S MAIDEN NAME Mary Dayhoff						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		INFORMANT Mrs. Pearl Duvall, Woodbine, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, by perforation, INTERVAL BETWEEN ONSET AND DEATH 1956								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arterosclerosis, arteroocclusive heart Dis. , DUE TO (c) Carcinoma left breast - DUE TO 16 Jan 60								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1956 , 19, to 16 Jan 60 , that I last saw the deceased alive on 11:50 PM 16 Jan 60 , and that death occurred 11:50 M , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Howard E. Hall</i>		ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED 17 Jan 60						
PHYSICIAN'S NAME (Type) HOWARD E. HALL								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-19-1960		22c. NAME OF CEMETERY OR CREMATORIAL Poplar Springs		22d. LOCATION (City, town, or county) Howard Co., Md.		
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR JAN 20 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Krause		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00759**

1. PLACE OF DEATH a. COUNTY Howard		0767 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		d. STREET ADDRESS Montevideo Road		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevideo Road						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CLAUDE LORAIN DAILEY		First	Middle	Last	4. DATE OF DEATH Jan. 21, 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11. 1877	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wyoming Pa.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Philip Dailey		14. MOTHER'S MAIDEN NAME Margaret Schooley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 049-14-3441		17. INFORMANT Janet D. Wagoner		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X <i>Cerebral Thrombosis</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 26 Hrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cachexia (Chronic)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> Donald E. Fisher								
ACTUAL SIGNATURE		DATE SIGNED		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Donald E. Fisher				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/22/60		22c. NAME OF CEMETERY OR CREMATORIAL Balla		22d. LOCATION (City, town, or county) Avoca Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Licenner Sons - N.Y.C. Md.		ADDRESS 17, md.		24a. REC'D BY REGISTRAR DATE JAN 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 with the registrar prior to burial, cremation, or removal.

WEIGHT EXERCISES, CHIEFLY OF DENSE MUSCLE TISSUE WHICH IS THE SOURCE OF ENERGY.

100 C. S. COOPER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00760

1. PLACE OF DEATH a. COUNTY <i>Baltimore, Howard</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shaefer Conv. Home</i>		d. STREET ADDRESS <i>764 Carroll Street #30</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Jan. 15 19 60	
3. NAME OF DECEASED (Type or print) <i>Mary</i>	First S.	Middle <i>Friese</i>	Last Month Day Year
4. SEX Female	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>Oct. 15, 1875</i>
8. AGE (In years last birthday) 84 yrs.	9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joseph Friese</i>		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -----	INFORMANT <i>Mrs. Charles L. MacCartlin-Equitable Trust Company</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO <i>Cerebral Thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks</i> <i>Cerebrovascular Cardiovascular disease</i> 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Frail, debilitated, etc.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11-27</i> , 19 <i>59</i> , to <i>1-15</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1-14</i> , 19 <i>60</i> , and that death occurred at <i>530 A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Thomas F. Herbert</i>		ADDRESS (Street, city or town, state) <i>46 Church Rd., Ellicott City, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Thomas F. Herbert, M.D.</i>		DATE SIGNED <i>1-15-60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/18/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Baltimore Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Tucker, Esq.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 18 1960</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Tracy</i>
ADDRESS <i>Baltimore - 17, Md.</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00761

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		0768		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge 27		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meadowridge Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ELIZABETH	Middle GARRETT	Last	4. DATE OF DEATH	Month Jan. 28, 1960	Day Year 19				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 3-15-1873	9. AGE (In years last birthday) 86 yrs.	10. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Kansas	12. CITIZEN OF WHAT COUNTRY?				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Samuel Garrett		14. MOTHER'S MAIDEN NAME Eleanor Matthews		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None					
17. INFORMANT Mrs. Marie Cecil, Elkridge, Md		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA, HEART FAILURE 4 DAYS		INTERVAL BETWEEN ONSET AND DEATH 260 X					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. HYPERTENSION, GENERALIZED ART.		DUE TO (b) DIABETES MELLITUS, VIRAL BRONCHITIS		DUE TO (c) DIABETES MELLITUS, VIRAL BRONCHITIS		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Elkridge (State) Md.	
21. I certify that I attended the deceased from NOV 26 JAN 1960 , and that death occurred at 7:20 AM , from the causes and on the date stated above.		ACTUAL SIGNATURE George E Groleau		ADDRESS (Street, city or town, state) 5608 Main St Elkridge 27, Md.		DATE SIGNED 1-29-60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-60		22c. NAME OF CEMETERY OR CREMATORIAL Good Shepherd		22d. LOCATION (City, town, or county) Ellicott City, Md					
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0769

CERTIFICATE OF DEATH

Reg. Dist. No.

00762

TO HOSPITAL OR HOSPITAL may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

Page 4

1. PLACE OF DEATH o. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood Park		c. LENGTH OF STAY IN 1b		51. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Harwood Park)		Elkridge, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7000 Athol Avenue		d. STREET ADDRESS 7000 Athol Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Edison M. Hughes, Sr.	Middle	Lost	4. DATE OF DEATH	Month January	Day 26	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29. 1890	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Year Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B & O Railroad		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Hughes, Sr.				14. MOTHER'S MAIDEN NAME Nannie Fore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. I		INFORMANT Mrs. Edna M. Hughes 7000 Athol Ave. #27		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X DUE TO Influenza 3da INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) acute coronary occlusion 2 hrs DUE TO Cardio Vascular disease 5 yrs (c) Diabetes Mellitus + Obesity 2 mos Complications 2 mos Arterial hypertension 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus + Obesity							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jan 26 1960					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 26 1960 to Jan 26 1960 that I lost sight of the deceased alive on Jan 26 1960 , and that death occurred at Elkridge, Md. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Elkridge, Md. DATE SIGNED 10/27/60							
ACTUAL SIGNATURE Bruce Brumbaugh, M. D.							
PHYSICIAN'S NAME (Type)		5609 Main St. Elkridge 27, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1 '29 '60		22c. NAME OF CEMETERY OR CREMATORIUM Meadowridge Cemetery		22d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave.							
ADDRESS				24a. REC'D. BY REGISTRAR JAN 29 '60		24b. REGISTRAR'S SIGNATURE Curious J. Frans	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0770

CERTIFICATE OF DEATH

Reg. Dist. No.

00763

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jessup</i>		c. LENGTH OF STAY IN 1b <i>26 yrs</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Gulfard Road</i>		e. STREET ADDRESS <i>Gulfard Road</i>				
3. NAME OF DECEASED (Type or print) <i>William Ashby Jenkins</i>		First <i>W</i>	Middle <i>Ashby</i>			
Last <i>Jenkins</i>		4. DATE OF DEATH <i>Jan. 29 1960</i>	Month <i>Jan.</i> Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	DATE OF BIRTH <i>Feb. 11, 1894</i>			
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years from birthday) <i>65 yrs.</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>General helper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>US Naval Gun Factory</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>			
13. FATHER'S NAME <i>George B. Jenkins</i>		14. MOTHER'S MAIDEN NAME <i>Fincham</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>W.W. 1</i>	17. INFORMANT <i>Chester W. Jenkins, Savage Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1/2 min.</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Ch. Myocardial Insuff.</i>		5 yrs.				
DUE TO (c) <i>Hypertensive Cardio-Vasc Disease</i>		57 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Savage</i>	(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from alive on <i>1/29/60</i> , 19		1/1/55, 19		10:30 A.M. 1/29/60	that I last saw the deceased ADDRESS (Street, city or town, state) <i>Savage, Md.</i>	
ACTUAL SIGNATURE <i>Frank E. Shibley, M.D.</i>		PHYSICIAN'S NAME (Type) <i>Frank E. Shibley, M.D.</i>		DATE SIGNED <i>1/29/60</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/1/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Savage Cemetery</i>	22d. LOCATION (City, town, or county) <i>Savage, Maryland</i>	(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Red W. McDonald, Laurel, Md.</i>		ADDRESS <i>Red W. McDonald, Laurel, Md.</i>	24d. REC'D BY REGISTRAR <i>Arthur S. Frank</i>	24c. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>		
VS A15 (4) 15M 10/57		DATE FEB 3 '60				

DEPARTMENT OF STATE—WASH. D. C.—

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0763

CERTIFICATE OF DEATH

Reg. Dist. No.

00764

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Scarsdale</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <i>Scarsdale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Scarsdale-Gulfard Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Caughy</i>		First <i>F.</i>	Middle <i>L.</i>
4. DATE OF DEATH <i>Lang</i>		Last <i>Lang</i>	Month <i>January</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>August 5, 1906</i>		9. AGE (In years lost birthday) <i>53 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Analyst</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>vs Inst</i>	
11. BIRTHPLACE (State or foreign country) <i>Ash Creek, Minnesota</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Lee Lang</i>		14. MOTHER'S MAIDEN NAME <i>Pearl Lillian Howell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>WW 2</i>	
17. INFORMANT <i>Army discharge records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>Arteriovenous fistula</i>		DUE TO <i>Arteriovenous fistula</i>	
(c) DUE TO <i>Arteriovenous fistula</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 25</i> , 1960, to <i>Jan 28</i> , 1960, that I last saw the deceased alive on <i>Aug 28</i> , 1960, and that death occurred at <i>Scarsdale</i> , M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>329 Prince George St. Laurel, Md.</i>	
ACTUAL SIGNATURE <i>Robert C. Wingfield</i>		DATE SIGNED <i>1/28/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/1/60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Pleasant Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Laurel, Lava</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Danoldson, Laurel, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>FEB 3 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Pirnia</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11-510771

CERTIFICATE OF DEATH

Reg. Dist. No.

00765

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Lawyers Hill Rd.		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge	
3. NAME OF DECEASED (Type or print) Rhoda C. Mehring		d. STREET ADDRESS Box 14, route 4, Old Lawyers Hill Rd.	
4. DATE OF DEATH Jan. 20/60		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Wilmington, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME late James H. Cloud		14. MOTHER'S MAIDEN NAME Mary J. —	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address John S. Mehring, Box 14, Route 4, Elkridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 2 Mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of colon with general carcinomatosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that I attended the deceased from Mar. 19, 59 , to Jan 20, 1960 , that I last saw the deceased alive on Jan 20, 1960 , and that death occurred at 420 T.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A.P. Von Schulz, M.D.</i>		ADDRESS (Street, city or town, state) 4818 Edmondson Ave., Balt., Md.	
PHYSICIAN'S NAME (Type) A.P. Von Schulz, M.D.		DATE SIGNED Jan 22, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23/60	
22c. NAME OF CEMETERY OR CREMATORIUM Odd Fellows Cemetery		22d. LOCATION (City, town, or county) Smyrna, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke, F.D. 4101 Edmondson Ave. Balt., Md.		24a. REC'D BY REGISTRAR DATE JAN 22 '60	
ADDRESS Witzke, F.D. 4101 Edmondson Ave. Balt., Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TOKYO, JAPAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0772

CERTIFICATE OF DEATH

Reg. Dist. No.

00766

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Marriottsville</i>		c. LENGTH OF STAY IN lb <i>5 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Marriottsville</i>		d. STREET ADDRESS <i>1 Stonington Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>AMELIA CATHERINE MOORE</i>		First	Middle	Last	4. DATE OF DEATH <i>Jan 11 1960</i>	Month	Day Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 2, 1883</i>		9. AGE (In years most birthday) <i>76 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Pinkney Baker</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Wade</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>M. Morris Moore - Marriottsville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153.8</i>		DUE TO <i>Carcinoma of Colon - generalized metastasis, intestinal obstruction,</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1957</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Anemia, bronchial pneumonia</i>				to <i>11 Jan 60</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Woodbine, Md.</i>			
20f. (City or town) <i>Woodbine, Md.</i>		(County) <i>Montgomery Co.</i>		(State) <i>Md.</i>			
21. I certify that I attended the deceased from <i>1957</i> , to <i>11 Jan 1960</i> , that I last saw the deceased alive on <i>11 Jan 1960</i> , and that death occurred at <i>4:30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Woodbine, Md.</i>		DATE SIGNED <i>12 Jan 60</i>			
ACTUAL SIGNATURE <i>Howard E. Hark</i>		M.D.					
PHYSICIAN'S NAME (Type) <i>HOWARD E. HARK</i>				SYKESVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-13-60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Morgan Chapel</i>		22d. LOCATION (City, town or county) <i>Woodbine, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Hark</i>		ADDRESS <i>Sykesville, Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur H. Hark</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur H. Hark</i>	
				DATE JAN 14 '60			

CERTIFICATE OF DEATH

John C. Smith
John C. Smith
John C. Smith

33 106 524

John C. Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0773

CERTIFICATE OF DEATH

Reg. Dist. No.

00767

TO HOSPITAL
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER C. MOORE		First WALTER	Middle C.
4. DATE OF DEATH Month JAN.	Day 9,	Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-19-1884
9. AGE (In years last birthday) 75	10. IF UNDER 1 YEAR yrs. Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY general	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Harry L. Moore		14. MOTHER'S MAIDEN NAME Katherine Bevard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) --	17. INFORMANT Robert D. Moore, same	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis, Arteriosclerotic			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) heart disease, likely, arteriosclerotic			
DUE TO (c) generalized			
INTERVAL BETWEEN ONSET AND DEATH 1955 to 8 Jan 1960			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19, to 9 Jan , 19 60 , that I last saw the deceased alive on 9 Jan , 19 60 , and that death occurred at 6:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i>		ADDRESS (Street, city or town, state) Winfield, Md.	
PHYSICIAN'S NAME (Type) HOWARD E. HALL		DATE SIGNED 10 Jan 60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-12-1960	22c. NAME OF CEMETERY OR CREMATORIUM Morgan Chapel	22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	24a. REC'D BY REGISTRAR DATE JAN 13 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Hank

1
FOR STATE
HEALTH DEPT.
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00768

1. PLACE OF DEATH

a. COUNTY

Howard

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Clarksville

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Home - Clarksville, Maryland

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

CATHY

ELIZABETH

MYERS

5. SEX

6. COLOR OR RACE

Female

Colored

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

August 28, 1959

9. AGE (In years
last birthday)
yrs.

IF UNDER 1 YEAR
Months Days Hours
14 14

IF UNDER 24 HRS.
Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Olney Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Caroline Jones, Clarksville, Maryland

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Asphyxia due to aspiration of stomach content

INTERVAL BETWEEN
ONSET AND DEATH

773.0

xx-xx-xx

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY
PERFORMED?

YES NO

2. MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

Russell S. Fisher

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

1/11/60

EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or country)

(State)

Burial

1-13-60

Locust Chapel

Simpsonville, Md

23. FUNERAL DIRECTOR

F.C. Higinbotham, Ellicott City, Md

24a. REC'D BY REGISTRAR

DATE JAN 15 '60

24b. REGISTRAR'S SIGNATURE

Ernest S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00769

0775

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL The law requires that the death certificate be executed within 24 hours of death. Page 4
TO ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville RFD Md		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookville RFD Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenelg		d. STREET ADDRESS Glenelg	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MINNIE	Middle OWINGS	Last 4. DATE OF DEATH Jan. 25, 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Glenelg, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Gillis Owings		14. MOTHER'S MAIDEN NAME Maria Dorsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Sue Owings, Glenelg, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial failure			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic heart disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Nephrosclerosis with uremia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 14, 1946 , to Jan. 25, 1960 that I last saw the deceased alive on Jan. 24, 1960 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles S. Whitaker</i>		ADDRESS (Street, city or town, state) Clarksville, Maryland	
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		DATE SIGNED 1-27-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-60	
22c. NAME OF CEMETERY OR CEMETORY Oak Grove		22d. LOCATION (City, town, or county) Glenwood, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE FEB 1 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

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2000 JOURNAL OF CLIMATE

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422 *Journal of Health Politics, Policy and Law*

1160 *W. J. H. Goss*

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TO HOSPITAL may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

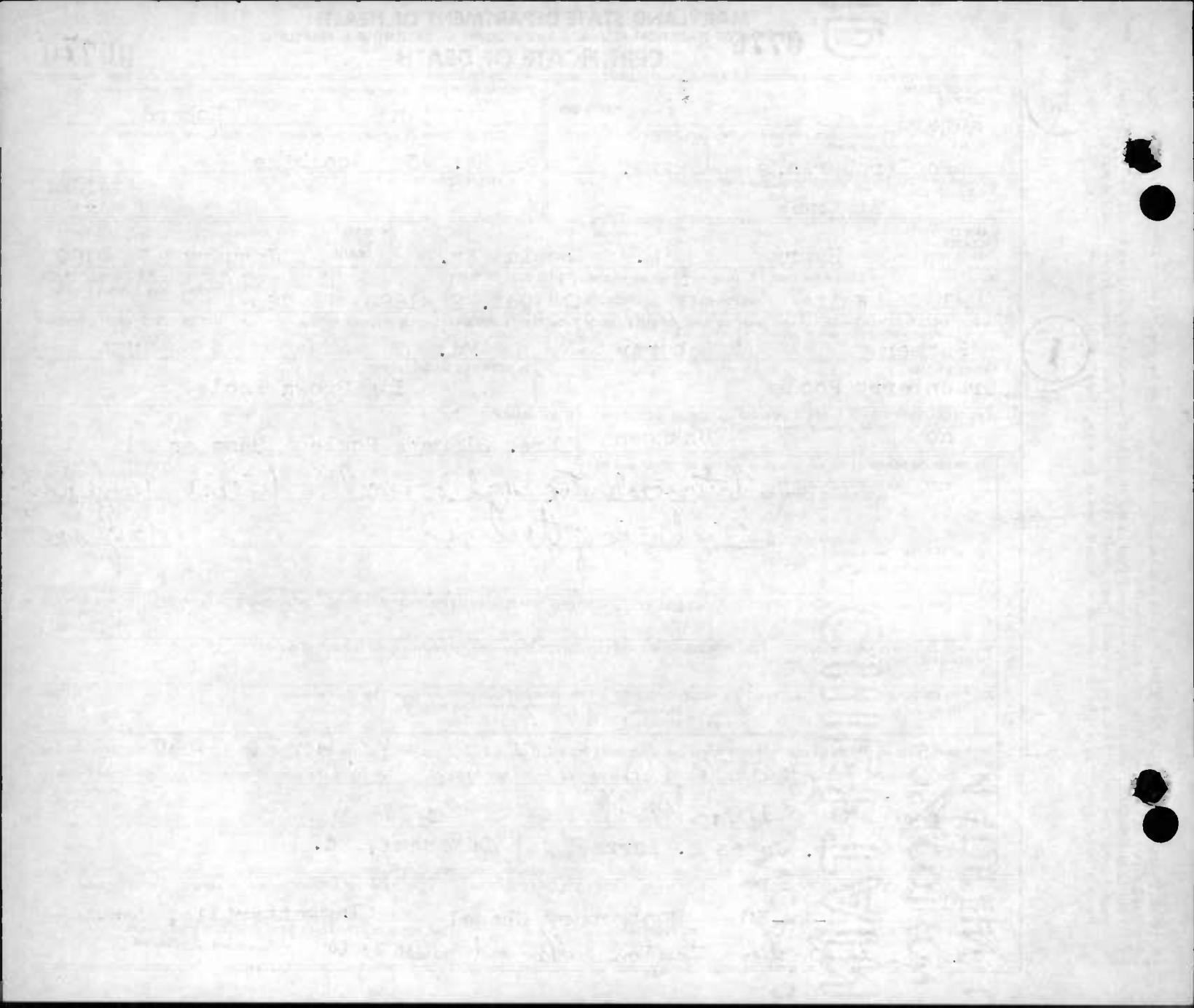
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 1 Film 6250 2-14-60 et

00770

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poplar Springs		c. LENGTH OF STAY IN 1b 2 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Howard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rt. #3 woodbine		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry		First M.	Middle Poole	Last Sr.	4. DATE OF DEATH January 26 1960	Month January	Day 26	Year 1960	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 2 1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 76	IF UNDER 24 HRS. Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Greenberry Poole		14. MOTHER'S MAIDEN NAME Ida Brown Poole							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Blanche Poole		Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteriosclerotic cardiovascular disease DUE TO 581.0 INTERVAL BETWEEN ONSET AND DEATH 10 years									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the liver DUE TO 10 years.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1960 to Jan. 16, 1960 that (I) (we) last saw the deceased alive on Jan. 16, 1960 and that death occurred at M. M., from the causes and on the date stated above.									
22a. SIGNATURE James P. Kerr M.D.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) D r. James P. Kerr		22d. ADDRESS Damascus, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-29-60		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Montgomery Chapel Laytonsville Md		23d. LOCATION (City, town, or county) (State) Claggettsville, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				25a. REC'D BY REGISTRAR Curtis L. Moore		25b. REGISTRAR'S SIGNATURE Curtis L. Moore			
				DATE JAN 29 '60					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. *00771*

1. PLACE OF DEATH a. COUNTY Howard		0758 MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna		First Middle May	Lost Richards	4. DATE OF DEATH January	Month Day 8 Year 19 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/01	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-store clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hampstead, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME <i>Constant Elseroad</i>		14. MOTHER'S MAIDEN NAME <i>Ida Milligan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-0101		17. INFORMANT Address Marshall Richards, husband- Hampstead, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x</i>		Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO					
(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pharyngitis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 24, 1959, to Jan 8, 1960, that I last saw the deceased alive on Jan 8, 1960, and that death occurred at 5:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Stephen Lee Magness</i> M.D. Taylor Manor Hospital DATE SIGNED <i>1/8/60</i>					
PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D., Taylor Manor Hospital, Ellicott City, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 11-1960		22c. NAME OF CEMETERY OR CREMATORIUM Wesley	
22d. LOCATION (City, town, or county) Carroll Co Md					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin C. Tipton - Hampstead Md</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 12 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

TO HOSPITAL OR
may be retained by
attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0759

CERTIFICATE OF DEATH

Reg. Dist. No. 00772

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (2)		d. STREET ADDRESS 1700 Selma Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				d. STREET ADDRESS 1700 Selma Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Clarence		First	Middle	Lost	4. DATE OF DEATH January 9	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/30/81	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired - Army		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Warriors' Mark, Pa		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Sp. Am. & WWI		17. INFORMANT Mohler Robison, son- 1/24 Winans Ave.		Address 27 Md. Baltó		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial failure		INTERVAL BETWEEN ONSET AND DEATH 72 hrs.				
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO						
DUE TO		Arteriosclerotic cardiovascular disease		unknown				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome associated with senile brain disease with				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from		Nov. 9	to	Jan 9	1960	that I last saw the deceased		
alive on		Jan 9	, 1960	and that death occurred at	12:40 P.M.	from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		Stephen Lee Magness		M.D. Taylor Manor Hospital		DATE SIGNED 1/9/60		
PHYSICIAN'S NAME (Type)		Stephen Lee Magness		M.D. Taylor Manor Hospital, Ellicott City, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/60		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cem.		22d. LOCATION (City, town, or county) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR DATE JAN 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Khan		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0760

CERTIFICATE OF DEATH

Reg. Dist. No. 00773

1. PLACE OF DEATH o. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS 106 B Main St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 B Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY ELIZABETH SHEPPARD		First	Middle	Lost	4. DATE OF DEATH Jan. 26, 1960	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1863	9. AGE (In years last birthday) 96	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dayton, Md		12. CITIZEN OF WHAT COUNTRY? Ruth Ellen Smith			
13. FATHER'S NAME Thomas Sheppard		14. MOTHER'S MAIDEN NAME Ruth Ellen Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Ida Sheppard, Ellicott City, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Vascular Disease		DUE TO 450.0		INTERVAL BETWEEN ONSET AND DEATH 14 years			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO				(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2-8 , 19 46 , to 1-13 , 19 60 , that I last saw the deceased alive on 1-13 , 19 60 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>George E. Burgtof</i> M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED 1-27-60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-60		22c. NAME OF CEMETERY OR CREMATORIY St. Johns		22d. LOCATION (City, town, or county) Ellicott City, Md			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00774

0777 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5831 Virlona Avenue		e. STREET ADDRESS 5831 Virlona Avenue	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Catherine Smithson		First	Middle
4. DATE OF DEATH January 24, 1960		Last	Month
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		8. DATE OF BIRTH May 16, 1876	9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Elijah Bush		14. MOTHER'S MAIDEN NAME Annie Bowers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Mr. James Smithson 5818 Virlona Avenue	
17. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x DUE TO Left Hemiplegia		today	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Paralysis of the right side		3:05	
(c) DUE TO Sonality		20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 14, 1960 to Jan 24, 1960 that I last saw the deceased alive on Jan 23, 1960 , and that death occurred at 12:59 P.M. from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) 120/60	
ACTUAL SIGNATURE Bruce Brumbaugh, M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) Bruce Brumbaugh, M. D.		5609 Main St. Elkridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 1 '27 '60	
22c. NAME OF CEMETERY OR CREMATORIUM St. Augustines Cem.		22d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR DATE JAN 27 '60	
		24b. REGISTRAR'S SIGNATURE Cynthia S. Kraus	

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film G258 3-15-60 et

0761

CERTIFICATE OF DEATH

Reg. Dist. No.

00775

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		b. COUNTY	
c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital		d. STREET ADDRESS 3707 Hudson St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George	Middle Joseph	Last Thomas Sr.
4. DATE OF DEATH	Month January	Day 21	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/10/16/92.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY CROWN, CORK & SEAL CO.	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.
13. FATHER'S NAME GEORGE THOMAS		14. MOTHER'S MAIDEN NAME ANNA SIHANEK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT HELEN M. THOMAS
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) Acute and chronic alcoholism		Address SAME.	
		INTERVAL BETWEEN ONSET AND DEATH 72 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hepatic cirrhosis, severe with ascites		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 16, 1960, to Jan. 21, 1960, that I last saw the deceased alive on Jan. 21, 1960, and that death occurred at 4:15 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Taylor Manor Hospital	
ACTUAL SIGNATURE Irving J. Taylor		DATE SIGNED 1/21/60	
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D., Taylor Manor Hospital, Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-25-60	22c. NAME OF CEMETERY OR CREMATORIUM SACRED HEART CEM.
22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Taylor		24a. REC'D BY REGISTRAR DATE JAN 25 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Turner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove, seal papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

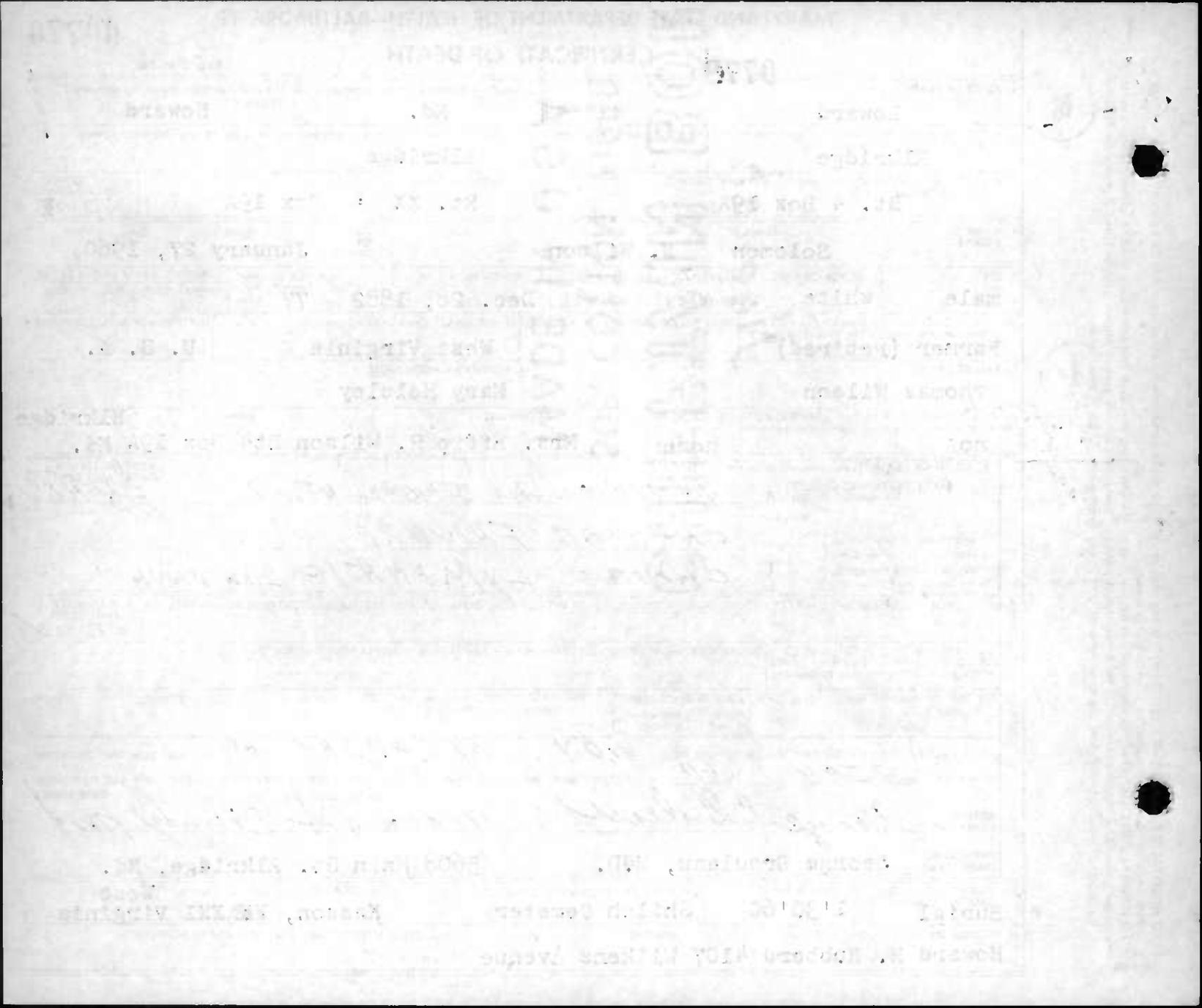
00776

CERTIFICATE OF DEATH

Reg. Dist. No.

0778

1. PLACE OF DEATH o. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 4 Box 19A		d. STREET ADDRESS Rt. 4 Box 19A	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Solomon N. Wilson	First	Middle	Last
4. DATE OF DEATH January 27, 1960,	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1882
9. AGE (In years last birthday) 77	IF UNDER 1 YEAR yrs.	IF UNDER 24 HRS. Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Thomas Wilson	14. MOTHER'S MAIDEN NAME Mary Helsley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	INFORMANT Mrs. Effie R. Wilson Rt 4 Box 19A Md.	Address Elkridge
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO CHRONIC LYMPHATIC LEUKEMIA			
VENTRICULAR FIBRILLATION INTERVAL BETWEEN ONSET AND DEATH 24 HRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) CARDIAC FAILURE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from NOV , 1959, to 27 JAN , 1960, that I last saw the deceased alive on 27 JAN , 1960, and that death occurred at 6-300 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Main St. Elkridge, Md.	
ACTUAL SIGNATURE <i>George Grouleau</i>		DATE SIGNED George Grouleau, Md.	
PHYSICIAN'S NAME (Type) George Grouleau, Md.		5608 Main St. Elkridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1:30 '60	22c. NAME OF CEMETERY OR CREMATORIUM Shiloh Cemetery	22d. LOCATION (City, town, or county) West Kasson, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue		ADDRESS	24a. REC'D BY REGISTRAR DATE
			24b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00777

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		0770		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fulton</i>		c. LENGTH OF STAY IN 1b <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fulton</i>		d. STREET ADDRESS <i></i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Edwin</i>	Middle <i></i>	Last <i>Wolfe, Sr.</i>	4. DATE OF DEATH <i>January 23 1960</i>	Month <i></i>	Day <i></i>	Year <i></i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>November 22 1881</i>	9. AGE (In years lost birthday) <i>78 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>John M. Wolfe</i>		14. MOTHER'S MAIDEN NAME <i>Laura Wolfe</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i></i>		
17. INFORMANT <i>Ray Wolfe Fulton Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> Congestive heart failure		19. INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i></i>		(b) Arteriosclerosis		years				
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause first. <i></i>		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	Year 1960	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>10/24 145</i> to <i>1/23 1960</i> , that I last saw the deceased alive on <i>1/18 1960</i> , and that death occurred at <i>315 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>J. R. Buek</i> M.D.								
PHYSICIAN'S NAME (Type) <i>John R. BUEK</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/26/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Waugh Chapel Cem.</i>		22d. LOCATION (City, town, or county) <i>Anne Arundel Co., Md</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Sanderson, Laurel, Md</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR <i></i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Turner</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

803
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG256 2-19-60 et

Reg. Dist. No.

00778

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		b. COUNTY Howard	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 19 New Cut Road		d. STREET ADDRESS 19 New Cut Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle MC KINLEY	Last WOODS	4. DATE OF DEATH 1-24-1960	Month Day Year 19
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Approx.	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME Patrick Woods	14. MOTHER'S MAIDEN NAME Mary Shipley
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 218-12-2285	17. INFORMANT Mary Offer 14 N. Mount St. Baltimore 23, Md
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2		30 min
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Chronic Myocardial Disease
DUE TO (c)		5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
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20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>Thomas F. Herbert</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 1-25-60
EXAMINER'S NAME (Type) Thomas F. Herbert, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) 1.25.60	22b. DATE THEREOF 1-25-60	22c. NAME OF CEMETERY OR CREMATORIUM Ellicott City Md.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>F.C. Higginbottom</i>	ADDRESS Ellicott City Md.	24a. REC'D BY REGISTRAR DATE FEB 2 '60	24b. REGISTRAR'S SIGNATURE <i>Elmer S. Kraus</i>
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